STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555387	A. BUILDING _____ B. WING _____	12/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE CENTER	**9107 N. DAVIS ROAD, STOCKTON, CA 95209 SAN JOAQUIN COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS AA CITATION -- PATIENT CARE 03-1662-0008293-S Complaint(s): CA00167537 Representing the Department of Public Health: Surveyor ID # 17069, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 72311 Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. (3) Notifying the attending physician promptly of: (B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient. Unannounced visits to the facility were initiated on 12/17/08 to investigate a facility self report #CA00167537. As a result of the investigation, the Department determined the facility failed to:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Continued From page 1 1) Continually assess Patient A 2) Promptly inform the resident's physician of a change in condition. Patient A was originally admitted to the facility on 06/13/02 with diagnoses including cerebral vascular accident (stroke), atrial fibrillation (irregular heart rhythm), and prior left hip prosthesis. Patient A's Quarterly Minimum Data Set (MDS, a standardized assessment tool) dated 10/27/08 documented Patient A as having short and long-term memory problems, as having severely impaired cognitive skills for daily decision making, was sometimes able to make herself understood and usually able to understand others. The MDS also documented Patient A as being dependent upon staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and bathing. The MDS further documented that Patient A had no behavioral symptoms including being resistive to care. She was unable to ambulate on her own and was only out of bed in a wheelchair. The facility reported that Patient A had suffered a cardio-respiratory emergency on 10/26/08. She was transported by paramedics to the local general acute care hospital (GACH) and attempts to resuscitate her were unsuccessful. While in the emergency room, it was discovered that she had sustained a recent leg fracture. Certified Nurse Assistant (CNA) 2 was interviewed on 12/22/08 at 10:15 a.m. She stated she first noticed Patient A's left knee was swollen on			

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	Continued From page 2 Thursday (10/23/08). When asked if she informed the LN (Licensed Nurse) of Patient A's condition she stated she "did not." When asked why she didn't inform the Licensed Nurse (LN) she stated in her "mind" it was "arthritis." CNA 2 stated Patient A's knee continued to be swollen the following day, Friday 10/24/08, and she had informed LN 3 of the change in Patient A. CNA 2 stated Patient A's left knee was still swollen on Saturday 10/25/08 but did not inform the charge nurse since she had already informed LN3 the day before (10/24/08). CNA 2 described Patient A's swollen knee as having no redness or bruising. CNA 2 confirmed she didn't document Patient A's swollen knee on the ADL (Activities of Daily Living) sheet on Thursday or Friday since she told LN 3 on Friday. CNA 2 also confirmed Patient A was not resistive to care when provided. CNA 2 was asked if she knew how Patient A's left lower extremity was injured she replied, "I have no idea." Review of Patient A's Interdisciplinary Progress Note (IPN) and Activity of Daily Living (ADL) sheets revealed no documentation on 10/23/08 regarding Patient A's lower extremity being swollen which was confirmed by CNA 2 as not being documented or being reported to LN 3. Review of Patient A's "Daily/Weekly Physical Therapy Progress Summary," the Physical Therapist (PT) documented, on 10/23/08, that Patient A was seen for range of motion on both upper and lower extremities, bed mobility and positioning. The plan of care was for Patient A to ambulate with the front wheel walker with			

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	Continued From page 3 assistance. The PT staff was interviewed via telephone on 12/22/08 at approximately 10:55 a.m. He stated he did not recall Patient A having any swelling, redness or bruising to her lower extremities and had no complaint of pain that day. The PT also stated Patient A was up in a wheelchair on 10/23/08. LN 3 was interviewed on 12/22/08 at 10:40 a.m. She stated CNA 2 informed her on Friday 10/24/08 at the end of their shift that Patient A's lower extremity was swollen. She stated upon assessment "Patient A's left foot, not knee, was swollen." She described Patient A's foot as having "no redness and she "elevated Patient A's foot on a pillow." She confirmed she did not document Patient A's condition in the resident's clinical record and could not recall if she informed the oncoming p.m. LN (LN 4) of Patient A's condition. LN 3 stated she wrote a late entry change of condition on 10/26/08. Review of Patient A's IPN revealed LN 3 made a late entry for 10/24/08 at 2:30 p.m. that documented a CNA reported Patient A had a swollen leg and that Patient A's feet were elevated on pillows. This entry was not made until 10/26/08 after Patient A expired. There was no other documentation in the IPN or ADL sheets on 10/24/08, the second day Patient A's lower extremity was observed to be swollen. LN 3 also could not recall if she had reported to the oncoming p.m. shift LN (LN 4) on 10/24/08 or indicated the			

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	Continued From page 4 need to contact Patient A's physician. Review of the facility's investigation report revealed LN 3 was interviewed by the facility's Director of Nursing (DON) on 10/27/08. LN 3 stated she was informed by CNA 2 (cared for Patient A on 10/23 and 10/24) at approximately 2-2:30 p.m. (date not indicated) that Patient A had a swollen knee. LN 3 stated she "did not look at the knee since it was end of her shift." LN 3 was asked if she informed the oncoming p.m. shift. LN 3 replied, "No." The facility's investigation report documented LN 4, who worked the p.m. shift on 10/24/08, was interviewed. LN 4 stated she was not given report of Patient A's left swollen knee on 10/24/08. LN 4 was interviewed, via telephone, on 12/29/08 at 1:00 p.m. LN 4 confirmed she did not receive report from the a.m. charge nurse (LN 3) or the a.m. CNA (CNA 2) regarding Patient A's swollen knee. According to the facility's investigation report LN 5 was interviewed. LN 5, who worked the p.m. shift on 10/25/08, stated "there was only slight swelling" of Patient A's left knee. He stated he called Patient A's physician and obtained an order for an x-ray. LN 5 also stated he contacted Patient A's family regarding her condition. LN 5 stated the x-ray company was not able to come out to the facility until 10/26/08, (after Patient A had been taken to the GACH). He confirmed he had not asked for a STAT (to be done immediately) x-ray. The investigation report noted above was not			

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	Continued From page 5 consistent with the Change of Condition Documentation dated 10/25/08 which noted, "notified by CNA - Resident left knee 4+ edema and swelling, ROM (range of motion) to left knee with facial expression of pain." The facility's investigation report further revealed CNA 6 was interviewed. CNA 6, who worked the p.m. shift on 10/24/08, stated he "did not notice a swollen left knee" on Patient A and "did not get report from the a.m. shift CNA (CNA 2) or charge nurse (LN 3) regarding Patient A's swollen knee. The facility's investigation report documented the following under the section, "Conclusion: Communication and follow through did not happen. CNA 2, who first noticed the swelling, did not inform the charge nurse on 10/25 a.m. shift since she had already told the charge nurse (LN 3) the day before (10/24/08), again poor communication and follow through by staff." An IPN dated 10/25/08, documented CNA 1 reported Patient A's left knee was swollen. The IPN documented on 10/25/08 at 2:00 p.m. a telephone call was placed to the physician and an order was received for an x-ray. An IPN, dated 10/26/08 at 5:08 a.m., documented Patient A was found unresponsive. Patient A's O2 Sat (oxygen saturation percentage - normal is > 93% on room air) was 46% and the Patient was not breathing. CPR (cardiopulmonary resuscitation) was started and 911 was called. The IPN documented paramedics arrived and took over			

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	Continued From page 6 CPR. Review of the "Interim Patient Care Report" (ambulance report), dated 10/26/08, documented Patient A was found "laying supine in bed with staff performing CPR." The ambulance report also documented that Patient A's left lower extremity "appeared to be shortened and rotated outward." Patient A's General Acute Care Hospital (GACH) records contained a form titled, "Nursing Notes," that documented Patient A's "left leg noted to be externally rotated and shortened. MD aware and x-ray ordered." The "Nursing Notes" documented the facility was contacted for report and the licensed nurse (LN), who was in charged of Patient A's care, gave no report that Patient A had any injuries. The "Nursing Notes" documented the local police department was notified due to Patient A having a "suspicious injury." The GACH x-ray of Patient A's upper leg, dated 10/26/08, documented, "....there is a spiral slightly comminuted (shattered into small pieces) fully displaced fracture of the distal femoral diaphysis (mid-portion of the thigh bone below the insertion of the hip prosthesis) .... The final impression was "distal femoral diaphyseal fracture, completely displaced." In a patient who is bedridden, this injury of unknown origin is significant. According to an overview of diaphyseal femur fractures obtained from emedicine.medscape.com/article/1246329 dated 12/24/08, the following information (in part) is			

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	Continued From page 7 included: "The femur is one of the longest and strongest bones in the human body...The femur has an abundant blood supply...Femoral shaft fractures are usually the result of trauma...pathologic fractures in adults are most often the result of osteoporoses and metastatic disease...Pain, swelling, shortening, and deformity are usually present in the region...Severe-to-life threatening injuries often occur along with femoral shaft fractures. Death, fat embolism, deep vein thrombosis, pulmonary embolism, pneumonia, multi-organ failure, infection, hemorrhage, etc...may occur as complications of diaphyseal fractures." Prompt splinting and stabilization of the fracture is necessary to minimize or prevent complications. According to the "Cardiac Arrest Data Sheet" Patient A expired on 10/26/08 at 5:50 a.m. The police department's "Incident Report" documented that the GACH Registered Nurse (RN) was interviewed and stated she observed Patient A's left leg as "bouncing around and hanging off the bed at times during the code (CPR)." According to the police report both the GACH RN and the ER physician observed Patient A's left leg and knee. "Her knee was severely swollen and her left leg was shortened and extremely rotated." The police report documented CNA 2, who provided care to Patient A, was interviewed. CNA 2 stated on 10/23/08 at around 10:00 a.m. she gave Patient A her daily sponge bath, changed her brief and			

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	Continued From page 8			

gown. CNA 2 stated she noticed Patient A's left leg was swollen at the knee. Her "left knee was larger that her right knee" and didn't know how it became swollen. CNA 2 stated it was the facility's policy to report any injuries found on a Patient and stated she "forgot to report [Patient A's] swollen knee to the Charge Nurse" and forgot to "write it in her notes." The police report documented that on Friday 10/24/08 CNA 2 again gave Patient A her daily sponge bath and stated Patient A's left knee was still swollen. She further stated the knee was about the same size as it was on Thursday. CNA 2 stated she reported the swollen knee to Licensed Nurse (LN) 3 who stated the swelling was "only arthritis" and the swelling was "not documented."

Review of the Autopsy Report, performed on 10/27/08, documented Patient A "died as a result of a fractured left femur." The final report indicated (in part) that the findings included: "(g) displaced oblique fracture... (h) Impingement and focal vascular injury of the left femoral artery with greater than I liter (quart) of blood estimated, dissecting into the soft tissue of the left thigh... (m) traumatic bone marrow embolization, and pulmonary fat embolism (material from the thigh bone marrow broke away and traveled thorough the veins to lodge and obstruct the circulation to the lungs, which is usually lethal."

The report further documented (in part) the following evidence of trauma:

"2. There is shortening of the left lower extremity accompanied by external rotation and flexion of the

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	Continued From page 9 hip and knee joints. 3. There is marked swelling and edema of the left hip, left thigh, and left knee. 5. There is diffuse extensive dissecting soft tissue hemorrhages of the left thigh...There is greater than one liter of blood estimated dissecting into the soft tissues of the left thigh." The Police Report included an interview with the son. The son had visited Patient A on 10/25 around noon and noted she was less responsive than usual and seemed "almost comatose." Later that day, the son was notified that Patient A's left knee was swollen and x-rays were ordered. That was the only notice he had been given that there was a possible injury. The next notice he had was when she was being transported to the GACH as an emergency patient. On 04/11/11, the son was interviewed by phone. He was concerned that his mother had suffered unnecessarily because of an injury of unknown origin. There was no evidence of ongoing assessment of Patient A's swollen left knee or periodic evaluation of Patient A's level of discomfort evidenced by facial grimacing. Patient A sustained an injury of unknown origin with a significant delay in physician notification and subsequent delayed treatment until complications forced emergency measures and transfer to the GACH for evaluation and emergency measures. The Department determined the facility failed to: 1. Continually assess Patient A.			

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	Continued From page 10 2. Promptly inform the resident's physician of a change in condition leading to a delay in medical evaluation and care. These violations presented either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom and were a direct proximate cause of death of Patient A.			

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7/6/11 LK for PD

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS AA CITATION -- PATIENT CARE 03-1662-0008293-S Complaint(s): CA00167537 Representing the Department of Public Health: Surveyor ID # 17069, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. 72311 Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. (3) Notifying the attending physician promptly of: (B) Any sudden and/or marked adverse change in signs, symptoms or behavior exhibited by a patient. Unannounced visits to the facility were initiated on 12/17/08 to investigate a facility self report #CA00167537. As a result of the investigation, the Department determined the facility failed to:		to begin immediately & be corrected by 6/21/11 CAC letter given on 6/15/11	

Event ID:N3TQ11 6/13/2011 2:37:04PM

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Judy Treloar Administrator 6/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Continued From page 1 1) Continually assess Patient A 2) Promptly inform the resident's physician of a change in condition. Patient A was originally admitted to the facility on 06/13/02 with diagnoses including cerebral vascular accident (stroke), atrial fibrillation (irregular heart rhythm), and prior left hip prosthesis. Patient A's Quarterly Minimum Data Set (MDS, a standardized assessment tool) dated 10/27/08 documented Patient A as having short and long-term memory problems, as having severely impaired cognitive skills for daily decision making, was sometimes able to make herself understood and usually able to understand others. The MDS also documented Patient A as being dependent upon staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and bathing. The MDS further documented that Patient A had no behavioral symptoms including being resistive to care. She was unable to ambulate on her own and was only out of bed in a wheelchair. The facility reported that Patient A had suffered a cardio-respiratory emergency on 10/26/08. She was transported by paramedics to the local general acute care hospital (GACH) and attempts to resuscitate her were unsuccessful. While in the emergency room, it was discovered that she had sustained a recent leg fracture. Certified Nurse Assistant (CNA) 2 was interviewed on 12/22/08 at 10:15 a.m. She stated she first noticed Patient A's left knee was swollen on		**F000 Initial Comments** **This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Creekside Care Center does not admit that the deficiency listed in this form exist, nor does the Center admit to any statements,findings, facts or conclusion that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy Treloar TITLE: Administrator (X6) DATE: 6/17/11

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Jivonne Bluford RN 6/17/11

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	555387	A. BUILDING _____ B. WING _____	12/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE CENTER	9107 N. DAVIS ROAD, STOCKTON, CA 95209 SAN JOAQUIN COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2 Thursday (10/23/08). When asked if she informed the LN (Licensed Nurse) of Patient A's condition she stated she "did not." When asked why she didn't inform the Licensed Nurse (LN) she stated in her "mind" it was "arthritis." CNA 2 stated Patient A's knee continued to be swollen the following day, Friday 10/24/08, and she had informed LN 3 of the change in Patient A. CNA 2 stated Patient A's left knee was still swollen on Saturday 10/25/08 but did not inform the charge nurse since she had already informed LN3 the day before (10/24/08). CNA 2 described Patient A's swollen knee as having no redness or bruising. CNA 2 confirmed she didn't document Patient A's swollen knee on the ADL (Activities of Daily Living) sheet on Thursday or Friday since she told LN 3 on Friday. CNA 2 also confirmed Patient A was not resistive to care when provided. CNA 2 was asked if she knew how Patient A's left lower extremity was injured she replied, "I have no idea." Review of Patient A's Interdisciplinary Progress Note (IPN) and Activity of Daily Living (ADL) sheets revealed no documentation on 10/23/08 regarding Patient A's lower extremity being swollen which was confirmed by CNA 2 as not being documented or being reported to LN 3. Review of Patient A's "Daily/Weekly Physical Therapy Progress Summary," the Physical Therapist (PT) documented, on 10/23/08, that Patient A was seen for range of motion on both upper and lower extremities, bed mobility and positioning. The plan of care was for Patient A to ambulate with the front wheel walker with		**72311 Nursing Service-General Corrective actions for residents affected** Resident's with a COC were/are audited by Medical Records (HIM) for notification to MD in a timely manner by License Nurse. **Identifying other residents having the potential to be affected, and what corrective action will be taken** Any resident with a COC noted by License Nurse or C.N.A.; License Nurse will notify the MD upon assessment for orders and Licensen Nurse will notify Responsible Party (RP) of COC	

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Judy Treloar	Administrator	6/17/11

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George Stefanov 6/17/11

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	Continued From page 3 assistance. The PT staff was interviewed via telephone on 12/22/08 at approximately 10:55 a.m. He stated he did not recall Patient A having any swelling, redness or bruising to her lower extremities and had no complaint of pain that day. The PT also stated Patient A was up in a wheelchair on 10/23/08. LN 3 was interviewed on 12/22/08 at 10:40 a.m. She stated CNA 2 informed her on Friday 10/24/08 at the end of their shift that Patient A's lower extremity was swollen. She stated upon assessment "Patient A's left foot, not knee, was swollen." She described Patient A's foot as having "no redness and she "elevated Patient A's foot on a pillow." She confirmed she did not document Patient A's condition in the resident's clinical record and could not recall if she informed the oncoming p.m. LN (LN 4) of Patient A's condition. LN 3 stated she wrote a late entry change of condition on 10/26/08. Review of Patient A's IPN revealed LN 3 made a late entry for 10/24/08 at 2:30 p.m. that documented a CNA reported Patient A had a swollen leg and that Patient A's feet were elevated on pillows. This entry was not made until 10/26/08 after Patient A expired. There was no other documentation in the IPN or ADL sheets on 10/24/08, the second day Patient A's lower extremity was observed to be swollen. LN 3 also could not recall if she had reported to the oncoming p.m. shift LN (LN 4) on 10/24/08 or indicated the		**Measures and systemic changes to prevent recurrence;** C.N.A. and License Nurses were re-educated by Director of Staff Development and DNS on; assessment, notification and documentation of any COC and immediate follow-through by license staff. **Monitoring Corrective Action for sustained corrections;** Any COC will be reviewed and audited daily (5 days/week) by Medical Records(HIM)/DNS and interdisiplinary team for appropriate notification and documentation. Administrator, DNS and Director of Staff Development will monitor the Plan of Correction for continued compliance and implementation **Completion date;** 6/20/2011	

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Judy Treloar Administrator 6/17/11

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Joanne Hoffman 6/17/11

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	Continued From page 4			

need to contact Patient A's physician.

Review of the facility's investigation report revealed LN 3 was interviewed by the facility's Director of Nursing (DON) on 10/27/08. LN 3 stated she was informed by CNA 2 (cared for Patient A on 10/23 and 10/24) at approximately 2-2:30 p.m. (date not indicated) that Patient A had a swollen knee. LN 3 stated she "did not look at the knee since it was end of her shift." LN 3 was asked if she informed the oncoming p.m. shift. LN 3 replied, "No." The facility's investigation report documented LN 4, who worked the p.m. shift on 10/24/08, was interviewed. LN 4 stated she was not given report of Patient A's left swollen knee on 10/24/08.

LN 4 was interviewed, via telephone, on 12/29/08 at 1:00 p.m. LN 4 confirmed she did not receive report from the a.m. charge nurse (LN 3) or the a.m. CNA (CNA 2) regarding Patient A's swollen knee.

According to the facility's investigation report LN 5 was interviewed. LN 5, who worked the p.m. shift on 10/25/08, stated "there was only slight swelling" of Patient A's left knee. He stated he called Patient A's physician and obtained an order for an x-ray. LN 5 also stated he contacted Patient A's family regarding her condition. LN 5 stated the x-ray company was not able to come out to the facility until 10/26/08, (after Patient A had been taken to the GACH). He confirmed he had not asked for a STAT (to be done immediately) x-ray.

The investigation report noted above was not

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	Continued From page 5			

consistent with the Change of Condition Documentation dated 10/25/08 which noted, "notified by CNA - Resident left knee 4+ edema and swelling, ROM (range of motion) to left knee with facial expression of pain."

The facility's investigation report further revealed CNA 6 was interviewed. CNA 6, who worked the p.m. shift on 10/24/08, stated he "did not notice a swollen left knee" on Patient A and "did not get report from the a.m. shift CNA (CNA 2) or charge nurse (LN 3) regarding Patient A's swollen knee.

The facility's investigation report documented the following under the section, "Conclusion: Communication and follow through did not happen. CNA 2, who first noticed the swelling, did not inform the charge nurse on 10/25 a.m. shift since she had already told the charge nurse (LN 3) the day before (10/24/08), again poor communication and follow through by staff."

An IPN dated 10/25/08, documented CNA 1 reported Patient A's left knee was swollen. The IPN documented on 10/25/08 at 2:00 p.m. a telephone call was placed to the physician and an order was received for an x-ray.

An IPN, dated 10/26/08 at 5:08 a.m., documented Patient A was found unresponsive. Patient A's O2 Sat (oxygen saturation percentage - normal is > 93% on room air) was 46% and the Patient was not breathing. CPR (cardiopulmonary resuscitation) was started and 911 was called. The IPN documented paramedics arrived and took over

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	Continued From page 6 CPR. Review of the "Interim Patient Care Report" (ambulance report), dated 10/26/08, documented Patient A was found "laying supine in bed with staff performing CPR." The ambulance report also documented that Patient A's left lower extremity "appeared to be shortened and rotated outward." Patient A's General Acute Care Hospital (GACH) records contained a form titled, "Nursing Notes," that documented Patient A's "left leg noted to be externally rotated and shortened. MD aware and x-ray ordered." The "Nursing Notes" documented the facility was contacted for report and the licensed nurse (LN), who was in charged of Patient A's care, gave no report that Patient A had any injuries. The "Nursing Notes" documented the local police department was notified due to Patient A having a "suspicious injury." The GACH x-ray of Patient A's upper leg, dated 10/26/08, documented, "....there is a spiral slightly comminuted (shattered into small pieces) fully displaced fracture of the distal femoral diaphysis (mid-portion of the thigh bone below the insertion of the hip prosthesis) .... The final impression was "distal femoral diaphyseal fracture, completely displaced." In a patient who is bedridden, this injury of unknown origin is significant. According to an overview of diaphyseal femur fractures obtained from emedicine.medscape.com/article/1246329 dated 12/24/08, the following information (in part) is			

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	Continued From page 7 included: "The femur is one of the longest and strongest bones in the human body...The femur has an abundant blood supply...Femoral shaft fractures are usually the result of trauma...pathologic fractures in adults are most often the result of osteoporoses and metastatic disease...Pain, swelling, shortening, and deformity are usually present in the region...Severe-to-life threatening injuries often occur along with femoral shaft fractures. Death, fat embolism, deep vein thrombosis, pulmonary embolism, pneumonia, multi-organ failure, infection, hemorrhage, etc...may occur as complications of diaphyseal fractures." Prompt splinting and stabilization of the fracture is necessary to minimize or prevent complications. According to the "Cardiac Arrest Data Sheet" Patient A expired on 10/26/08 at 5:50 a.m. The police department's "Incident Report" documented that the GACH Registered Nurse (RN) was interviewed and stated she observed Patient A's left leg as "bouncing around and hanging off the bed at times during the code (CPR)." According to the police report both the GACH RN and the ER physician observed Patient A's left leg and knee. "Her knee was severely swollen and her left leg was shortened and extremely rotated." The police report documented CNA 2, who provided care to Patient A, was interviewed. CNA 2 stated on 10/23/08 at around 10:00 a.m. she gave Patient A her daily sponge bath, changed her brief and			

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	Continued From page 8			

gown. CNA 2 stated she noticed Patient A's left leg was swollen at the knee. Her "left knee was larger that her right knee" and didn't know how it became swollen. CNA 2 stated it was the facility's policy to report any injuries found on a Patient and stated she "forgot to report [Patient A's] swollen knee to the Charge Nurse" and forgot to "write it in her notes." The police report documented that on Friday 10/24/08 CNA 2 again gave Patient A her daily sponge bath and stated Patient A's left knee was still swollen. She further stated the knee was about the same size as it was on Thursday. CNA 2 stated she reported the swollen knee to Licensed Nurse (LN) 3 who stated the swelling was "only arthritis" and the swelling was "not documented."

Review of the Autopsy Report, performed on 10/27/08, documented Patient A "died as a result of a fractured left femur." The final report indicated (in part) that the findings included: "(g) displaced oblique fracture... (h) Impingement and focal vascular injury of the left femoral artery with greater than I liter (quart) of blood estimated, dissecting into the soft tissue of the left thigh... (m) traumatic bone marrow embolization, and pulmonary fat embolism (material from the thigh bone marrow broke away and traveled thorough the veins to lodge and obstruct the circulation to the lungs, which is usually lethal."

The report further documented (in part) the following evidence of trauma:

"2. There is shortening of the left lower extremity accompanied by external rotation and flexion of the

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	Continued From page 9			

hip and knee joints.
3. There is marked swelling and edema of the left hip, left thigh, and left knee.
5. There is diffuse extensive dissecting soft tissue hemorrhages of the left thigh...There is greater than one liter of blood estimated dissecting into the soft tissues of the left thigh."

The Police Report included an interview with the son. The son had visited Patient A on 10/25 around noon and noted she was less responsive than usual and seemed "almost comatose." Later that day, the son was notified that Patient A's left knee was swollen and x-rays were ordered. That was the only notice he had been given that there was a possible injury. The next notice he had was when she was being transported to the GACH as an emergency patient. On 04/11/11, the son was interviewed by phone. He was concerned that his mother had suffered unnecessarily because of an injury of unknown origin.

There was no evidence of ongoing assessment of Patient A's swollen left knee or periodic evaluation of Patient A's level of discomfort evidenced by facial grimacing. Patient A sustained an injury of unknown origin with a significant delay in physician notification and subsequent delayed treatment until complications forced emergency measures and transfer to the GACH for evaluation and emergency measures.

The Department determined the facility failed to:

1. Continually assess Patient A.

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	Continued From page 10 2. Promptly inform the resident's physician of a change in condition leading to a delay in medical evaluation and care. These violations presented either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom and were a direct proximate cause of death of Patient A.			

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